Board Meeting 6/17/09
Agenda Item 6(a)

Analysis of SB 227 (Alquist)
Amended 05/28/2009

PURPOSE

SB 227 (Alquist) would expand the state's capacity for serving medically uninsurable persons through the Major Risk Medical Insurance Program (MRMIP).

SUMMARY

SB 227 would achieve its purpose by requiring carriers in the individual and (to a limited extent) the group insurance market to either pay a fee to support MRMIP, the State's high-risk pool, or provide coverage directly to medically uninsurable persons assigned to carriers by the State. SB 227 would set the maximum fee amount in statute. It would probably make MRMIP eligible for federal high-risk pool funding by eliminating the annual benefit cap of $75,000. It would authorize MRMIB to base the amount of subscriber premiums for lower income individuals on family income. It would allow the Board to increase the level of premiums from the current level (125-137.5% of the standard market rate) up to 150% of the standard market rate. It would require MRMIB to make several reports to the Legislature on program implementation, alternative ways of providing coverage to medically uninsurable individuals, and the adequacy of rates charged for preferred provider organization (PPO) coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

POSITION AND SUPPORTING ARGUMENTS: SUPPORT

The MRMIB Board took a support position on AB 1971 (Chan, 2006-07) and AB 2 (Dymally, 2007-08), which contained substantially similar provisions to SB 227. SB 227 offers a partial solution and an infusion of funds to provide health coverage to more medically uninsurable Californians willing and able to purchase it. Since its inception eighteen years ago, MRMIP has been subject to a capped appropriation with reductions in recent years. This situation has required MRMIB to repeatedly lower enrollment from a high of over 27,000 in 1999 to its current, capped level of 7,100 individuals. This represents a fraction of the state's medically uninsurable residents, estimated at between 165,000 and 396,000 in 2004, who are uninsured and unable to purchase insurance in the private insurance market.

In considering AB 1971 at its March 22, 2006 Board meeting, the MRMIB Board adopted the following principles to guide its decision in taking a position on the bill. These principles can be applied to the current-year bill, SB 227. Ideally, the bill should:

- Provide sufficient funding to make comprehensive health coverage available to all medically uninsurable individuals who are willing to purchase it. Eliminate

annual benefit caps that result in cost-shifting to medically uninsurable individuals, thereby making benefits in MRMIP more compatible with the needs of the target population.
- Spread the cost of subsidizing coverage for high-risk individuals across all health insurers and health care service plans in the group and individual market so that the ultimate cost does not fall disproportionately on a small number of health insurance purchasers.
- Permit MRMIB to address premium affordability for low-income subscribers in calculating the necessary funding for MRMIP.
- Remove disincentives for carriers to participate in MRMIP and thereby promote consumer choice of health plans within MRMIP.

In considering SB 227 in light of the principles above, MRMIB staff provides the following summary:

Pro

- The bill would provide an additional source of revenue for MRMIP.
- The bill would eliminate annual benefit caps that result in cost-shifting to medically uninsurable individuals and would make benefits in MRMIP more compatible with the needs of the target population.
- The bill would make it more likely that MRMIP could qualify for federal funding for state high-risk pools (by eliminating the annual benefit cap).
- The bill would spread the cost of subsidizing coverage for high-risk individuals across a somewhat larger pool of health insurers and health care service plans.
- The bill would permit MRMIB to address premium affordability in calculating the necessary funding for MRMIP.

Con

- The bill provides a limited source of funds for MRMIP while increasing the potential cost of premiums to 150% of the standard market rates, which could make the program less affordable for moderate income individuals.
- The bill would continue the approach (shared by California and most other states) under which individuals pay more for health coverage simply because of health conditions that are generally beyond their control.

Conclusion

SB 227 probably would not provide sufficient funding to make comprehensive coverage available to all medically uninsurable individuals willing to purchase it. However, the bill does provide a new, stable funding source that would substantially increase the number of medically uninsurable Californians who could purchase coverage through MRMIP. By eliminating the annual benefit cap, the bill would probably make MRMIP eligible for federal high-risk pool funding. It would spread the cost of providing coverage across a somewhat larger group of insurers and health care

plans. On balance, since SB 227 in its current form appears to meet some but not all of the Board's guiding principles, MRMIB staff recommends the Board take a Support position on the bill.

BACKGROUND

MRMIP Funding, Premiums and Enrollment

MRMIP is a high risk health insurance pool that provides access to comprehensive health insurance coverage for Californians who are unable to obtain coverage in the private individual market because they are considered to be medically uninsurable. MRMIP has been accepting subscribers since 1991. MRMIP subscribers pay monthly premiums at rates significantly higher – between 125 percent and 137.5 percent – than standard market rates for coverage from private health plans and insurers under contract with MRMIB. Subscriber premiums cover 60% of the total cost of the program. The remaining 40% of the program's cost is subsidized by the state, primarily with Cigarette and Tobacco Surtax Fund (Proposition 99) funds.

State funding for the program has been about $40 million annually ($30 million in the MRMIP statute, $10 million through annual or one-time appropriations) in most years but has been reduced in recent years. MRMIB has established enrollment caps to ensure that costs do not exceed these annual appropriations. This year, the state budget crisis has resulted in the proposed reduction of $6.6 million in state (Proposition 99) funding for the program for 2009-10. Even before this proposed funding cut, the annual MRMIP appropriation has been inadequate to fully fund the program and has resulted in long waiting lists during much of MRMIP's existence. Furthermore, in order to avoid even more restrictive enrollment caps and higher premiums, MRMIB adopted, by regulation, a $75,000 annual benefit cap for the program. While fewer than one percent of subscribers reach the benefit cap each year, those who do are high-cost individuals who must bear the costs or liability for treatment themselves or forego needed health care. Nineteen percent of MRMIP subscribers make no medical claims at all and 80 percent have claims at or under five thousand dollars annually, despite being a population of medically uninsurable individuals, as determined by plan actuaries.

State costs for MRMIP have grown significantly each year, further reducing the number of individuals who can be enrolled in the program. Even with the infusion of carrier revenue through GIP, in May 2006 MRMIB had to establish a new MRMIP waiting list and a requirement that total enrollment in the program be further reduced through attrition. Between May and September 2006, the waiting list grew to over one thousand individuals. In 2006, a one-time appropriation of an additional $4 million dollars (SB 1702, Speier, Chapter 683, Statutes of 2006) permitted MRMIB to offer enrollment to everyone on the waiting list. However, budget cuts and the sunset of GIP to new subscribers resulted in MRMIP waiting lists again in December 2007 and many times since.

Subscriber premiums in MRMIP appear to be unaffordable for many uninsured, uninsurable individuals. Depending on subscribers' incomes, MRMIP premiums range from six to 36 percent of annual family income. Annual disenrollment surveys of former MRMIP subscribers show that significant numbers disenroll because they cannot afford the monthly premium (51.1 percent, 45.6 percent, 22.9 percent, and 30.6 percent of those disenrolled in 2003, 2004, 2005 and 2006, respectively).

The GIP Program

In 2002, AB 1401 (Thomson, Chapter 1168, Statutes of 1989), established GIP in which subscribers were limited to 36 consecutive months of enrollment in MRMIP after which they were eligible for post-MRMIP guaranteed issue coverage in the private market. Every health plan and insurer that sold individual health policies in the private market was obligated to offer a statutorily-defined guaranteed issue product to these former MRMIP subscribers. Each GIP product was identical to a MRMIP product, except that the annual GIP benefit cap was $200,000 rather than $75,000. MRMIP and GIP products all had maximum lifetime benefits of $750,000.

Unlike MRMIP, in which the state pays for most of the losses associated with care provided to subscribers, in GIP the carriers and the state equally share the losses resulting from any additional health care provided to subscribers. The state's contributions to MRMIP and GIP are funded by the annual $40 million (or lower) appropriation; sharing the cost of the GIP subsidy between the state and the carriers permitted coverage of more individuals with the same level of appropriation.

The legislation creating GIP sunset on January 1, 2008 and MRMIP ceased the 36-month MRMIP disenrollments on September 30, 2007. However, under current law, GIP plans must continue to provide coverage to existing GIP subscribers and the costs over and above subscriber premiums are shared by MRMIB and the plans. In addition, there is a twelve month "lock-out" period from MRMIP for GIP subscribers who voluntarily disenroll from GIP plans.

High Risk Pools in Other States

According to *"Comprehensive Health Insurance for High-Risk Individuals/A State-by-State Analysis,"* published annually by the National Association of State Comprehensive Health Insurance Plans (NASCHIP), 34 states, including California, administer high risk pools for medically uninsurable individuals. California's MRMIP is one of three state high risk pools that are funded only with state dollars and consequently have enrollment caps. Most states use some form of carrier assessment to finance their pools. Some states that do not directly fund their high risk pools with state dollars offset a portion of the carrier assessments through state tax credits. Despite California's population, MRMIP is only the seventh largest state high risk pool. In 2007, with enrollment of about 6,900 MRMIP subscribers and about 6,000 GIP subscribers, MRMIP enrollment fell behind that of Minnesota, Texas, Oregon, Wisconsin, Illinois, and Maryland.

The federal Trade Act of 2002 provided the first infusion of federal funds for state high risk pools, with funding based on the number of uninsured individuals in each state. Additional federal funding has been made available for states with a "qualified high risk pool." California has been unable to receive federal funding because MRMIP does not meet the statutory criteria, primarily because of the $75,000 annual benefit cap.

In 2006, California was awarded a $150,000 federal "seed grant" to perform a "feasibility study." The study resulted in the following findings:

1. MRMIP differs significantly from other high risk pools in how it structures and offers benefits to subscribers. For example, more health plans participate in MRMIP than in other state high risk pools but MRMIP offers only one benefit design while other states offer various coverage packages.

2. Case, disease, benefit and pharmaceutical benefits management techniques are widely leveraged by plans contracting with MRMIP, as is the case in other states.

3. While disease and case management programs have been found to improve health status, there is little reliable data on cost savings.

4. Unlike MRMIP at the time of the study, most high risk pool subscribers in other state had deductibles. MRMIP has since implemented a $500 deductible that excludes preventive services.

The 2006 study also contained key recommendations:

1. Allowing for a greater annual limit may greatly benefit the less than 1 percent of MRMIP subscribers who accrue higher costs and may not require any increase in state appropriations.

2. MRMIB could consider the possibility of high deductible plans which may lower costs for many subscribers but there are serious unanswered questions that should be evaluated.

LEGISLATIVE HISTORY

AB 1971 (Chan, 2006): AB 1971 failed passage by the Legislature. The bill would have supplemented MRMIP's capped appropriation with a monthly "per covered life" fee on health insurers' and health care service plans' insured, "administrative services only" and "leased network" lives. MRMIB supported AB 1971, as did consumer groups (Health Access, AARP, Older Women's League) and the California Medical Association. Several carriers supported some versions of AB1971: Blue Cross of California, Blue Shield of California, Kaiser and Health Net. The carriers that supported AB 1971 have significant individual market business; three (Blue Cross, Blue Shield and Kaiser) are participating carriers within MRMIP. Opposition to AB 1971 included

carriers not participating heavily in the individual market, such as Aetna, Cigna, and Pacificare.

SB 1702 (Speier and Cox, Chapter 683, Statutes of 2006): SB 1702 appropriated an additional four million dollars to MRMIP in 2006 and extended the GIP sunset date to January 1, 2008. Pursuant to SB 1702, MRMIB performed its last 36-month MRMIP disenrollments on September 30, 2007.

AB 2 (Dymally, 2007-08): AB 2 was passed by both houses of the Legislature but was vetoed by the Governor. The bill would have expanded the state's capacity for serving medically uninsurable individuals by requiring carriers in the individual insurance market to either pay a fee to support MRMIP or provide coverage directly to medically uninsurable individuals assigned to carriers by the State. It would have required the State to provide $40 million in Proposition 99 funds for MRMIP annually, the same amount MRMIP received each year for most of the last 12 years. It most likely would have made MRMIP eligible for federal high-risk pool funding by eliminating the annual benefit cap of $75,000. It authorized MRMIB to base the level of MRMIP subscriber premiums for lower income subscribers on family income. In his veto message, however, the Governor stated that AB 2 would make "health care more expensive for those who can least afford it" because it would increase the cost of individual coverage.

ABX1 3 (Dymally, 2007): AB X1 3 was substantially the same as AB 2: it required health plans and insurers licensed in California to either pay a fee towards funding MRMIP or provide guaranteed issue coverage to medically high-risk persons. ABX1 3 failed passage in the Assembly Health Committee.

ANALYSIS

SB 227 would do the following:

Coverage and Eligibility

Guaranteed Coverage: SB 227 would require health plans and insurers that provide individual or group coverage to serve individuals eligible for MRMIP, as assigned by MRMIB, regardless of health status or previous health care claims experience, or to pay a statutorily defined fee per covered life to help fund MRMIP coverage. This is similar to AB 2 (except the last iteration), although SB 227 requires the fee paid for group lives to be assessed at a 1/10 as that for individual lives. SB 227 would have the effect of spreading the cost of subsidizing coverage for high-risk individuals across all health insurers and health care service plans in the individual market and requiring some level of contribution for the group market. This requirement may remove some disincentives for carriers to participate in MRMIP and would thereby potentially promote greater consumer choice of health plans within MRMIP.

Ineligibility: SB 227 would explicitly state MRMIB's current authority to apply an ineligibility period for MRMIP to an individual who voluntarily disenrolls from or is terminated for non-payment of premium from a participating health plan.

Deductible Cap: This bill would delete the existing annual limit of $500 on any MRMIP deductible. It would not establish a new maximum but would leave the deductible level up to MRMIB's determination.

Pre-existing Condition Exclusion Period: SB 227 would reword MRMIB's current authority to allow participating health plans that do not utilize a preexisting condition provision to impose a waiting or affiliation period. During this period, subscribers are not required to make the premium payments.

Benefits

Benefit Level: SB 227 would require the plans and insurers electing to cover individuals assigned to them by MRMIB to provide comprehensive coverage at the level determined by MRMIB, comparable to what MRMIP currently provides.

Benefit Limits: SB 227 would require no annual benefit cap, thereby repealing the current $75,000 annual limit. The bill would also raise the maximum lifetime benefit limit from $750,000 to no less than $1 million.

Funding

Augmentations: SB 227 does not contain Proposition 99 funding augmentations as previous bills did.

Fee Per Covered Life: SB 227 would require MRMIB to establish annual fees to be paid by health plans and insurers in the individual and group markets choosing to pay on a per covered life per month basis rather than providing coverage to eligible individuals. The bill would prohibit the fee from exceeding $1 per covered life per month. It would allow carriers to pay quarterly, based on the relative number of covered lives, and would require the fees to be paid to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) and then transmitted to MRMIB within 30 days of receipt. The bill would prohibit plans and insurers from including CalPERS members when counting "covered lives." Health plans and insurers providing group health care coverage would be allowed to count every 10 enrolled individuals in a group as one covered life. The bill would also allow plans or insurers renting or leasing a contracted network of providers to a group to count every 10 individuals in a group as one covered life.

Premiums: The bill would require MRMIB to establish subscriber premiums at not more than 150% of the standard average individual rate for comparable coverage. For subscribers at or below 300% of the federal poverty level (FPL), the bill would require a sliding scale with lower contribution requirements, but in

no case would subscriber contributions be permitted to be lower than 110% of the standard average individual rate for comparable individual coverage, unless federal funds are received. Currently, premiums in MRMIP are set in statute at between 125 and 137.5% of the standard average individual rate for comparable coverage; most if not all current premiums are at the 125% level.

By allowing MRMIB to reduce premiums for subscribers with incomes at or below 300%FPL, the bill would potentially make the program more affordable for some individuals who cannot currently afford subscriber premiums. However, with limited funding and the potential increase in premiums to the 150% level, subscriber premiums could become less affordable for some moderate income individuals.

General Fund Loan: SB 227 would authorize MRMIB to obtain a General Fund loan, to be repaid with interest, subject to the approval of the Department of Finance, by January 1, 2017. This loan could help with the program transition costs.

Reduce Cost-Sharing for Certain Services: By January 1, 2011, the bill would require lower subscriber cost-sharing for primary and preventive health services and for services that treat chronic conditions than for other services. Current law does not differentiate MRMIP subscribers' cost-sharing by type of service.

Excess Revenues: SB 227 would require MRMIB to use revenues that exceed operational costs for the MRMIP program to reduce the fee paid by health care service plans and health insurers in the following year.

Administration

Process for Assigning Enrollees: SB 227 would require MRMIB to develop a process to assign medically uninsurable persons to carriers that choose not to pay the fee.

Voluntary Re-enrollment of GIP Subscribers: SB 227 would require MRMIB to establish a process for GIP enrollees to voluntarily re-enroll into MRMIP. This re-enrollment would be conditioned on the absence of a MRMIP waitlist and other conditions. The bill would require MRMIB to offer slots in MRMIP based on the date each person was disenrolled from MRMIP (oldest date of termination is first offered). It would also require MRMIB to determine the maximum number of individuals who may return from each GIP carrier consistent with the proportion of GIP enrollees covered by each carrier.

Advisory Panel: SB 227 would require MRMIB to appoint an 11-member MRMIP advisory panel by February 1, 2010. It would require the panel to include representatives of four carriers providing coverage in the individual market (at least three of which participate in MRMIP), two MRMIP subscribers, two health care providers with expertise with treating chronic diseases, at least

one of whom is a doctor, and three organizations representing health care consumers and medically uninsurable persons. It would also require two ex-officio (non-voting) members: the Department of Managed Health Care (DMHC) Director and the Department of Insurance (DOI) Commissioner or their designees.

Reports to Legislature: SB 227 would require MRMIB to report to the Legislature on the implementation of the bill by July 1, 2012, including an implementation and transition plan, by January 1, 2014, for an alternative approach to ensuring quality coverage for high risk, potentially high cost individuals.

The bill would also require MRMIB to make recommendations to the legislature by September 1, 2010 regarding the status of benefits and premiums provided to individuals eligible for guaranteed-issue HIPAA coverage. Since MRMIB is not the regulatory or enforcement agency for this insurance coverage, this requirement would be better placed on the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI), the responsible agencies.

Emergency Regulation Authority: The bill would provide MRMIB, the DOI and DMHC with emergency regulatory authority, as needed to implement this bill.

Standards for Plan Participation: SB 227 would restate existing law and require MRMIB to establish the scope of coverage for the program and minimum standards for plan participation and when so doing to include guidelines for disease management, case management, care management or other cost management strategies that ensure cost-effective and high quality services.

The bill would continue to permit MRMIB to offer more than one benefit design option with different subscriber cost sharing in the form of copayments, deductibles, and annual out-of-pocket costs, and would require benefits, subscriber cost sharing, and out-of-pocket costs to be appropriate for a program serving high-risk and medically uninsurable persons.

The bill would also permit MRMIB to exclude from the subscriber contribution that portion of the standard average individual rate that is attributable to the elimination of the annual benefit maximum and to the increase in the lifetime benefit maximum. This is an important provision for providing affordable coverage to subscribers.

Waitlist Enrollment: Upon receipt of federal funds and contingent upon the amount and their allowable use, SB 227 would require MRMIB to offer enrollment to individuals who are on the waiting list, if any. When there is not a waiting list, it would require the Board to lower premiums for subscribers at or below 300% of the federal poverty level to no less than 6% of income, and would also permit lower subscriber contributions for subscribers over 300% but

less than 400% of the federal poverty level to no less than 6% of income with any remaining federal funds. The bill would require any remaining federal funds to be used to recalculate the fee charged to plans and insurers that elect to not provide guaranteed-renewable coverage to persons assigned by MRMIB.

Plan/Insurer Reporting

SB 227 would require health plans and insurers to annually notify MRMIB as to whether they will cover individuals assigned to them or pay a fee as determined by MRMIB. It would further require plans and insurers to report to MRMIB the total number of covered lives by May 1 of each year.

The bill would require the Guaranteed Issue Program (GIP) plans and insurers to report at least annually the number of covered lives remaining in continuation coverage.

FISCAL IMPACT

MRMIB assumes all carriers will elect to pay fees rather than provide assigned coverage to eligible individuals. In analyzing AB 2 (Dymally, 2008), MRMIB concluded that, given there are approximately 1.8 million lives in the individual market, if MRMIB sets the fee at the maximum limit of $1 per covered life and each covered life corresponds with one person, the fee would bring in about $18 million in revenue from the individual market. Given that SB 227 requires that group carriers count each 10 persons as one covered life, we would expect the provider fee to provide an additional, unknown amount of revenue annually.

In 2008, MRMIB estimated the cost of eliminating the annual benefit limit at $400 annually per subscriber.

Administrative Costs

MRMIB estimates that administrative costs for implementing SB 227 would be similar to those estimated for AB 2 in 2008. MRMIB estimates that at least 4.5 additional positions would be needed to implement the bill's requirements. Estimated costs are about $185,000 in 2009/10 and $475,000 annually thereafter.

In addition, about $400,000 would be needed in 2009/10 and $500,000 annually thereafter to fund:

- Increased costs of the administrative vendor for the increased enrollment and system changes;
- Consultants to assist with required reports; and
- Additional actuarial services

With these costs, the percentage of funds spent on administration would be about 5 percent of overall program revenue.

Federal Funding

If MRMIB eliminates the annual benefit limit as required by SB 227, CMS will probably consider MRMIP a "qualified high-risk pool", making the program eligible for federal funds provided for state high-risk pools.

SUPPORT/OPPOSITION

Support as of 06/01/2009

American Federation of State, County and Municipal Employees
California Association of Health Underwriters (if amended)
California Communities United Institute
California Medical Association
Congress of California Seniors
Health Access California

Opposition as of 06/01/2009

Aetna
Cal-Tax
California Department of Insurance Commissioner
California Manufacturers and Technology Association
California Right to Life Committee, Inc.
Howard Jarvis Taxpayers Association

VOTES

Date	Location	Vote	Result
06/03/2009	Sen. Floor	(Yes: 23 No: 15 Abstain: 2)	(Pass)
05/28/2009	Sen. Appr.	(Yes: 8 No: 3 Abstain: 2)	(Pass)
05/04/2009	Sen. Appr.	(Yes: 11 No: 0 Abstain: 2)	(Pass)
04/22/2009	Sen. Health	(Yes: 10 No: 1 Abstain: 0)	(Pass)